Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HILL COUNTRY HEALTHCARE SYSTEMS
6521 SAN PEDRO
SAN PEDRO TX 78216

Respondent Name

SOUTHWEST ISD

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-10-2038-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "pre-authorized services"

Amount in Dispute: $7800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier will stand on the denial of the services made the basis of this dispute." "The requestor failed to contact the correct Preauthorization agent for this self insured governmental entity. Additionally the requestor provided incorrect claim information to the agent they did contact." "It is unclear how the Requestor came to contact the incorrect designated agent for Preauthorization for Southwest ISD and how an Preauthorization was provided for this injured worker under incorrect Employer information."

Response Submitted by: Pappas & Suchma, PC, P.O. Box 66655, Austin, TX 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 2, 2008 December 3, 2008 December 5, 2008 December 8, 2008 December 9, 2008 December 10, 2008 December 11, 2008 December 12, 2008 December 15, 2008 December 16, 2008 December 17, 2008 December 18, 2008 December 22, 2008	Chronic Pain Management – CPT code 97799-CP (6 hours/day)	$600.00/day	$00.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204. Medical Fee Guideline for Workers' Compensation Specific Services. March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, effective May 2, 2006, 31 TexReg 356, requires preauthorization for chronic pain management program.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 18, 2008
   - Unnecessary medical treatment based on peer review.

   Explanation of benefits dated December 31, 2008
   - Payment denied/reduced for absence of precertification/authorization.

   Explanation of benefits dated January 7, 2009
   - Payment denied/reduced for absence of precertification/authorization.

   Explanation of benefits dated January 8, 2009
   - Payment denied/reduced for absence of precertification/authorization.

   Explanation of benefits dated January 14, 2009
   - 197-Payment denied for absence of precertification/authorization/notification.

   Explanation of benefits dated January 23, 2009
   - Payment denied/reduced for absence of precertification/authorization.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.

   Explanation of benefits dated February 3, 2009
   - Payment denied/reduced for absence of precertification/authorization.
   - 197-Payment adjusted for absence of precertification/authorization/notification.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.
   - Notes: Pre-auth was not obtained from the correct pre-auth company.

Issues

1. Was the dispute submitted timely per 28 Texas Administrative Code §133.307?
2. Did the requestor support position that preauthorization was obtained for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. ... A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the services in dispute are December 2, 2008 through December 22, 2008. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on December 10, 2009. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that dates of service December 2, 2008 through December 9, 2008 were submitted untimely with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these dates of service. Dates of service December 10, 2008 through December 22, 2008 were submitted timely and will be reviewed per applicable Division rules and guidelines.
2. The respondent denied reimbursement for the disputed services based upon reason code 197-Payment denied for absence of precertification/authorization/notification. "

   The respondent states in the position summary that "The requestor failed to contact the correct Preauthorization agent for this self insured governmental entity. Additionally the requestor provided incorrect claim information to the agent they did contact." "It is unclear how the Requestor came to contact the incorrect

designated agent for Preauthorization for Southwest ISD and how an Preauthorization was provided for this injured worker under incorrect Employer information."

28 Texas Administrative Code §134.600 (e) The carrier shall designate accessible direct telephone and facsimile numbers and may designate an electronic transmission address for use by the requestor or employee to request preauthorization or concurrent review during normal business hours. The direct number shall be answered or the facsimile or electronic transmission address responded to by the carrier within the time limits established in subsection (i) of this section.

The requestor submitted two preauthorization reports dated November 25, 2008 and December 17, 2008 from Review Med, L.P. The respondent states that Review Med, L.P. is not the correct preauthorization agent for the self insured governmental entity. The requestor did not indicate how they obtained the incorrect preauthorization agent. Because preauthorization was not obtained from the respondent or respondent's preauthorization agent, the EOB denial of "197" is supported. As a result, no reimbursement can be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307 for dates of service December 2, 2008 through December 9, 2008. The Division further concludes that the requestor failed to support its position that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		4/30/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.